ELECTRODIAGNOSTIC STUDY INFORMATION

Patient Name: _____ Date of study: _____
Patient Age: _____ Date of Birth: _____
Patient Height: _____

Referring physician name and address: _____
_____
_____

Chief Complaint / Main reason you are here for the test: _____

What body parts are most affected? _____

When did this problem begin? _____

How did this problem start? _____

Is there anything that makes this problem better? _____

Is there anything that makes this problem worse? _____

Do you have:
- ☐ Pain
- ☐ Muscle Weakness
- ☐ Fatigue
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Falls
- ☐ Change in feeling/ numbness
- ☐ Clumsiness
- ☐ Loss of control of your bladder or bowel
- ☐ Change in swallowing
- ☐ Difficulty with rapid movement
- ☐ Eyelid drooping
- ☐ Change in vision
- ☐ Periods of inappropriate or exaggerated laughing or crying

Have you ever had an EMG study before? ☐ Yes ☐ No If so when and where? _____
Have you had X-rays, MRI scans? ☐ Yes ☐ No If so when and where? _____

Do you have any other medical problems?
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ High cholesterol
- ☐ History of cancer

Are you taking: ☐ Aspirin ☐ Plavix ☐ Blood thinners (Warfarin)
Do you have an implanted pacemaker or defibrillator? ☐ Yes ☐ No

Does anyone in your family have a disease that involves the muscles or nerves? ☐ Yes ☐ No

If yes, please specify: _____

Physician to complete the following:
- ☐ Muscle atrophy -/+: _____
- ☐ Focal weakness -/+: _____
- ☐ Change in sensation -/+: _____
- ☐ Reflexes: Normal/ Incr/ Absent: _____
- ☐ Other info: _____

Reviewed by: _____
Deanna Janora, MD